CERTIFICATION OF CUSTODIAN

MINHYE PARK

vs.

N/A

I am the authorized Custodian of Records for: QUEENS SURGICAL CARE CENTER and I have the authority to certify the attached records of:

MINHYE PARK, 11 CHANGWON-DAERO 397BEON, -GIL,UICHANG-GU HILL
STATE ARTRIUM CITY, ,
SSN: N/A, DOB: 12/15/1988
MEDICAL RECORDS & DIAGNOSTIC FILMS ON CD

Being duly sworn according to law, I hereby certify, depose and say that these records were searched and reproduced in my presence at my direction. These records were prepared in the ordinary course of business by authorized personnel on or about the time of the event or act and careful search for the records has been made by me or under my direction. Therefore, these records constitute all the records of said individual described above.

I HEREBY CERTIFY THAT THE FOLLOWING IS TRUE AND CORRECT:

A: I HAVE ATTACHED 10 PAGES / _____ # OF X-RAYS.
B: THIS INCLUDES ALL MATERIAL REQUESTED.
C: THIS INCLUDES ALL CORRESPONDENCE BETWEEN ALL FACILITIES.
D: I HAVE ATTACHEDTHE PATIENT INFORMATION SHEET OR ID SHEET WHEN APPLICABLE.
E: PRIOR APPROVAL REQUIRED FOR FEES IN EXCESS OF $250 FOR HOSPITALS AND $150 FOR ALL OTHER PROVIDERS.

2/22/2021
Date

**Sign Here

THE DOCUMENTS REQUESTED ARE NOT IN OUR POSESSION DUE TO THE FOLLOWING:

___ No Records **Read below
___ Records Destroyed After _____ Years

___ No X-Rays ** Read below
___ X-Rays Destroyed After _____ Years

Other _____

It is to be understood that this does not mean that the requested information does not exist under another spelling or another name. However, with the information furnished to our office and to the best of my knowledge, **I certify the above to be a true and accurate statement.**

Date

**Sign Here

MUST SIGN AND RETURN THIS PAGE!

CE01 - 49908-03

C0, S1

Today's Date 11/27/17 Physician D Kim 2

Patient Information/ Registration

Patient Name: Last PARK First Minhye	Date of Birth: [redacted] Age: Place of Birth or Ethnicity:
Street Address: 43-11 220th St	
City, State, Zip: Flushing NY 11361	Home telephone:
Cell Phone: (917)683-3535	Employer: Phone:
Marital Status ☒ Single ☐ Married ☐ Widowed/Divorced	Misc. Info.
Height 5'3 Weight 110	☐ Male ☐ Female
May we leave messages on your answering machine? ☐ Yes ☐ No (note: the representative from our office will never leave any personal health information on an answering machine)	
Emergency Contact: Min Relationship: Friend	Telephone (917) 873-0019
Have you been seen by our practice before: ☐ Yes ☐ No	Date of Last Visit
Who is picking you up after surgery? Friend	
What number can we reach you at the day after your surgery?	

Insurance Information

DR D KIM 11-27-17
PARK. MINHYE
F. DOB 12/15/1988

Primary Insurance

Company Name:	Policy ID# / Group ID#	Allergies
none		

Secondary Insurance

Company Name:	Policy ID#	Asthma	Heart Disease
		Diabetes	
		Rh	IV

If Policy Holder is other than the Patient, please complete the following:

Policy Holder Name:	Date of Birth	High Blood Pressure

Referring Physician Information

Physician Name:	Is this the primary care giver? ☐ Yes ☐ No
Street Address:	If not, name of PCP:
City, State, Zip:	Telephone:

I authorize the release of medical information which could include HIV status, communicable disease, or drug abuse information to and from my primary care and referring physician(s), outside laboratories or consultants, if needed, in the course of my examination and treatment and as necessary to process insurance claims, insurance applications and prescriptions until revoked in writing. I also authorize payment of medical benefits to the physician and QSCA LLC. I understand and agree that regardless of my insurance status, I am responsible for the balance of my account for any professional services rendered.

By signing this form I assure the information provided is complete and accurate to the best of my knowledge. If any of the above information should change, I understand that it is my responsibility to inform the organization of such changes. I have reviewed and understand, and a copy of the following information has been made available to me: **Information regarding the ownership of the practice; the expertise of the associated physicians; the Patient Rights and Responsibilities; the Patient Grievance Process; Notice of Privacy Practice.**

Signature of Patient or Responsible Party — Minhye Park (Printed Name) — 11/27/17 (Date)

Last Name First Name DOB / / Date / /

Patient Medical History

*** Please use back of form if more space is needed

ALLERGIES: (list all meds and reactions) ☐Penicillin ☐Iodine ☐Tetracycline ☐Novocain ☐Ampicillin ☐Seafood ☐Other

none

List all Present Illnesses/ Recent Diagnosis/Previous Surgeries:

Tsp

List all medications, herbs, OTC medications, vitamins currently taking

None

Have you had any previous negative reaction to anesthesia? ☐Yes ☒No If yes please explain

Do you take any of the following medications? ☐ Coumadin/ Warfarin ☐ Plavix ☐ Aspirin ☐ NSAIDs ☒NONE
Any issues related to: ☐ Sight Impairment ☐Hearing ☐ Communication: Language
Do you have a cough/cold /stuffy nose ☐Yes ☒No Do you have? ☐ Dentures ☐ Contact Lenses ☐ Loose Teeth
When was the last time you had something to eat? 9 AM/PM Drink? 9 AM/PM
Do you smoke? ☒Yes ☐No Use Alcohol? ☒Yes ☐No Frequency
Do you use any of the following? ☐ Amphetamines ☐ Crack ☐ Cocaine ☐ Heroin ☐ Marijuana ☐ Valium
☐ Other drug Last time used

Who is taking you home after the proceduere? Friend

Do you have a personal or family history of any of the following? S (Self) F (Family) No (None)

	S	F	No		S	F	No		S	F	No
Abdominal Pain/ cramps	☐	☐	☐	Gastrointestinal Bleeding	☐	☐	☐	Mitral Valve prolapse	☐	☐	☐
Acid reflux/ heartburn	☐	☐	☐	Gonorrhea (V.D.)	☐	☐	☐	Nausea/ Vomiting	☐	☐	☐
Anemia	☐	☐	☐	Heart Disease	☐	☐	☐	Osteoporosis	☐	☐	☐
Asthma or Lung Disease	☐	☐	☐	Heart Murmur	☐	☐	☐	Ovarian cysts	☐	☐	☐
Bleeding (Excessive)	☐	☐	☐	Hepatitis C	☒	☐	☐	Polyps	☐	☐	☐
Cancer (type)	☐	☐	☐	Herpes	☐	☐	☐	Pulmonary embolus	☐	☐	☐
Chlamydia	☐	☐	☐	High Blood Pressure	☐	☐	☐	Sickle cell anemia/ trait	☐	☐	☐
Clinical Depression	☐	☐	☐	HIV/AIDS	☐	☐	☐	Sleep Apnea	☐	☐	☐
Diabetes	☐	☐	☐	Infection of the Uterus,	☐	☐	☐	Stomach Ulcer	☐	☐	☐
Diarrhea	☐	☐	☐	Ovaries (PID)				Syphilis (V.D)	☐	☐	☐
Digestive disease	☐	☐	☐	Irritable Bowel Syndrome	☐	☐	☐	Thyroid Problem	☐	☐	☐
Epilepsy, convulsions, seizures	☐	☐	☐	Kidney problems	☐	☐	☐	Tuberculosis	☐	☐	☐

Menstrual Cycle Information

Yes No
☐ ☐ Bleeding/spotting since last menstrual period? When?
☐ ☐ Do you have cramping?
☐ ☐ Periods are usually every 25-35 days? If NO how often?

How many days do you flow

Date of Last Menstrual Period 10/16/17

Previous problems with deliveries or abortions?

Date of Last Pregnancy Test
Previous Pap Smears results: ☐ None ☐Normal ☐Abnormal

Previous surgical procedures on your cervix: ☐None ☐Colposcopy ☐Leep ☐Cryo ☐Cone biopsy ☐Laser

Birth Control Methods Used: ☐None ☐Pills ☐Patch ☐Depo ☐Condoms ☐ Sponge ☐Nuvaring ☐Diaphragm ☐ IUD ☐BTL

Previous Pregnancies

How many times have you been pregnant? 2

Number of live births

Number of Vaginal deliveries

Number of Caesarean sections

Number of abortions 2

Number of miscarriages

Have you had an Ectopic pregnancy? If so how many?

Do you have any questions you wish to remember to ask the doctor?

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE AND COMPLETE.

Patient's Signature Date 11/27/17

QSCC Corporation
136-20 38th Ave Suite 51
Flushing NY 11354
Tel (71 39-7474

NewPath Diagnostics
42-11 Parsons Blvd., 1st Floor
Flushing, NY 11355
Tel: (718) 321-1108
Fax: (718) 321-0158 / (718) 408-1477

DR. ___ DR D KIM 11-27-17
PARK, M NHYE
F. DOB [redacted]

PATIENT INFORMATION

Last Nam | First Name | M.I. | D.O.B. | ☐ M ☑ F

Street Address | Apt# | City | State

Phone | SSN | Insured name (if different from patient) | Insured D.O.B.

INSURANCE INFORMATION (ATTACH COPY OF INSURANCE CARD)

Insurance Name | I.D. # | Group #

☑ Bill QSCC ☐ Bill Client ☐ Bill Insurance ☐ Self ☐ Spouse ☐ Child

Physician Name | NPI #

SPECIMEN INFORMATION

Date Collected	Time AM PM	Fasting ☐ hr ___	Fax results to:	Call results to:	STAT

It is the ordering party's responsibility to order only those tests medically necessary for the diagnosis and treatment of the patient.

ICD9 code							

HISTOPATHOLOGY REQUEST

INFORMATION BELOW IS IMPORTANT FOR PROPER INTERPRETATION

CLINICAL DIAGNOSIS

PERTINENT MEDICAL HISTORY / OPERATIVE FINDINGS

PREVIOUS SURGERY
(IF EXAMINED AT THIS LAB INCLUDE PATHOLOGY #)

IF GYN SPECIMEN: LMP ___ month / day / year

☐ Oral Contraceptives
☐ Pregnant
☐ Post Abortion
☐ Post Partum
☐ IUD
☐ Post Menopausal
☐ Hormonal therapy (Specify)
☐ Abnormal Bleeding
☐ DES Exposure

TYPE OF SKIN BIOPSY

JAR#:__ ☐ PUNCH
JAR#:__ ☐ SHAVE
JAR#:__ ☐ INCISIONAL
JAR#:__ ☐ EXCISIONAL
JAR#:__ ☐ EXCISIONAL WITH MARGIN EXAMINATION

SITE OF BIOPSY:

JAR#:__ ☐ ENDOCERVIX
JAR#:__ ☐ ENDOMETRIUM
JAR#:__ ☐ CERVICAL POLYP.
JAR#:__ ☐ ENDOMETRIAL POLYP.
JAR#:__ ☐ CONE BIOPSY
JAR#:__ ☑ P.O.C.

PLEASE IDENTIFY CONTAINERS (NOT LIDS) WITH PATIENT NAME

For Lab Use Only

136-20 38th Ave, Sui DR D KIM 11-27-17
PARK, MINHYE
F. DOB 12/15/1988

Patients Name: [illegible] Date of Birth: [redacted] Da

Informed Consent for Termination of Pregnancy

I hereby give my full and informed consent to: Dr. D Kim and his/her associates at QSCA LLC to terminate my pregnancy. I have considered my alternatives regarding this pregnancy and I voluntarily and of my own free will consent to the termination of pregnancy procedure.

I authorize the above physician and/or his/her associates to carry out such diagnostic procedures, administer treatment, anesthetics and/or medications, as he/she may deem necessary and advisable to insure my proper treatment.

My physician has fully explained the risks, and drawbacks involved as well as the possibility of complications from the procedure, including [illegible] and the benefits of the procedure. We have also discussed alternatives including no treatment; to the procedure along with those risks and benefits. I am aware that no guarantee or assurances as to the results of the procedure have been made and I have been told that no guarantee of results could be made. By signing this consent, I agree that all the foregoing has taken place to my satisfaction

I have received pre and post-operative (before and after) instructions; both written and verbal. I was given a chance to ask questions and all of my questions have been answered to my satisfaction. I am aware of the recovery period required as well as any potential problems I may encounter during this time

I represent that my medical history is accurate including medical conditions, use of medications, allergies to medications, use of any drugs (such as marijuana, crack, cocaine, heroin, valium, codeine) or alcohol. I am aware that withholding information regarding my medical history or use of drugs could be life threatening, and that the physicians treating me are NOT responsible for complications related to the information that I withhold.

Therefore, I authorize my physician in addition to any assistants whom he/she might designate, to perform this operation together with any preoperative or postoperative treatment upon me.

I authorize the operating physician to perform any procedures, which he may deem necessary in attempting to improve the condition for which I am being treated or any unforeseen condition that he may encounter during the operation.

I also consent to the administration of anesthesia, general, IV sedation, or local, to be applied by or under the direction of the Anesthesia Department and /or the operating physician, and the use of such anesthetics as deemed advisable. I understand the risks, complications and potential benefits of anesthesia; as well as potential problems associated with anesthesia during the recovery phase. These risks include but are not limited to, nausea and vomiting, trouble breathing, low blood pressure, cardiac arrhythmia, cardiac arrest, death.

I consent to observers in the procedure room as approved by my physician for the purpose of training or quality assurance. I authorize my physician to disclose complete information concerning his medical findings and treatment for the undersigned, from the initial consultation until date of the conclusion of such treatment, to those individuals who in my physicians sole determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.

Patient _____ Date _____ Witness _____

Guardian/Responsible Party _____ Relationship _____

I _____ have fully discussed and explained to _____
All the procedures and risks involved in the above identified procedure and hereby certify that I have explained the nature, purposes, benefits, risks, and alternatives to the proposed procedure, and have offered to answer any questions and have fully answered all such questions. I believe the patient fully understands what I have explained and answered.

Physician Signature _____ Date 11/27/17

DR D KIM 11-27-17
PARK, MINHYE
F, DOB [redacted]

Consent for Anesthesia

I hereby authorize the anesthesiologist Dr. Kim or his/her colleague, to administrate intravenous sedation (MAC), general, or local anesthesia on me for the proposed procedure. The anesthesiologist has fully explained to me the nature, benefits, risks, possible complications and alternative treatments for the anesthesia, including no anesthesia. These risks include but are not limited to, nausea, vomiting, trouble breathing, pneumonia, aspiration, low blood pressure, cardiac arrhythmia, cardiac arrest, or death. I understand that I should not have eaten food or drank fluid at least eight hours prior to the procedure. I also understand the necessity for an escort and the potential risks in traveling after anesthesia without an escort. I have been given an opportunity to ask questions and all my questions have been answered.

Assignment and Release

I authorize the release of any personal and medical information necessary to process this claim. I permit copy of this authorization to be used in place of the original. I authorize Dr. Kim to apply for benefits on my behalf for covered services rendered by him or his order. I request that payment from my insurance company be made directly to the doctor. I certify that the information I have reported with regard to my insurance coverage is correct.

Patient's Name (Print): _____ Signature: X _____

Witness's Name (Print): _____ Signature: _____

Physician's Signature: _____ Date: 11/27/2017

Patient discharge and Escort

Patient Received: Mediation Prescription ☐ Y / ☒ N Discharge Instruction ☒ Y / ☐ N

Patient Signature: PARK

Name of Responsible Adult Who Will Take Patient Home

Print: _____ Sign: PARK Date: 11/27/17

* Friend is Lourdais

QSCA
136-20 38TH Ave. 5I
Flushing,NY 11354
Tel. 718-939-9200

Date: November 27, 2017

OPERATIVE REPORT

Name of patient: MINHYE PARK
Patient date of birth: [redacted]

Preoperative Diagnosis: ELECTIVE TERMINATION OF PREGNANCY
Procedure: SUCTION DILATATION AND CURETTAGE
Postoperative Diagnosis: ELECTIVE TERMINATION OF PREGNANCY

Surgeon: David Kim, MD Assistant: None
Anesthesiologist: Guo, MD Anesthesia: MAC
Complications: None.
Estimated Blood Loss: 20 mL
Specimen(s): PRODUCTS OF CONCEPTION.

Description of Operative Procedure:

After risks and benefits of options were discussed with the patient, informed consent was signed and obtained. Patient understands and accepts possible risks of suction dilatation and curettage, including but not limited to bleeding, perforation of the uterus, infection, perforation of the uterus (with or without possible injury to organs surrounding the uterus (including but not limited to the urinary bladder and/or the bowel), cervical laceration, retained products of conception, Asherman's syndrome, and/or pain. Informed consent was signed and obtained. Patient voided urine in the bathroom, and then was transferred to the operating room.

MAC anesthesia was given by Dr. Guo. Patient was then placed in the dorsal lithotomy position, the patient was prepped and draped in sterile fashion. Sterile heavy weighted speculum was placed in the posterior portion of the vaginal vault. A Sims speculum was placed in the anterior portion of the vaginal vault. An Allis clamp was used to grasp the anterior lip of the cervix. The endocervical canal was gently and gradually dilated with Hanks dilators. A 6 mm suction curette was used to perform a suction curettage. A sharp curettage was then gently performed throughout the endometrial cavity until a gritty texture was appreciated. A suction curettage was repeated to remove the remaining products of conception. All instruments were then removed from the vagina. Excellent hemostasis was visualized. Instrument and sponge count were correct times two. Patient was transferred to the recovery room in stable condition.

Discharge Instructions:

1. Pelvic rest: No sex, no tampons, no douche, and no tub baths for 3 weeks.
2. Call Dr. Kim and go immediately to NY Presbyterian-Queens ER if fever, severe abdominal pain, or heavy vaginal bleeding.
3. Advil 400mg po q 6 hours with food for 3 days prn pain.
4. Follow up with Dr. Kim in the office in 3 weeks.

DR D KIM 11-27-17
PARK, MINHYE
F, DOB [redacted]

Anesthesia Record

Patient's Name: _____ D.O.B.: __

Diagnosis: Top Date: _____

Procedure: Sinus I&D Time: 0900 11:40

PREOPERATIVE EVALUATION

Medical History:
HTN: YES( ) NO( ) DM: YES( ) NO( )
CAD: YES( ) NO( ) ASTHMA: YES( ) NO( )
OTHER: YES( ) NO( ) BLEEDING TENDENCY: YES( ) NO( )

Surgical History: Top
Medication:
Allergies:

BP: 130/77 HR- 77 O2Sat 99
Height: Weight: 110 lb
Cardiovascular:
Pulmonary:
Airway Assessment:
Lab:
N.P.O. Status:
ASA Class: 2

Time	15	30	45	15	30	45	Total
O2 (L/M)	3						
Midazolam							
Propofol (ml)	60	50	20				
Ketamine(mg							
Fentanyl(ug)							
IV							
Ventilation							
ECG							
Pulse Ox							
NIBP 180							
160							
140							
120							
100							
80							
HR 60							
40							

Anesthesia Management:

Consent obtained
Monitors Applied
IV line Placed
Time Out Prior To Procedure
Anesthesia Type: GA ( ) MAC ( )
Airway Management ( )

Remark

RECOVERY & DISCHARGE

Time:	BP:	HR:	O2Sa:	RR:
12:10	100/60	62	98	17

VNS

Discharge Criteria

Vital Signs Stable: ( )
Alert and Oriented X 3: ( )
Absence of Pain: ( )
Able to Ambulate: ( )
No anesthesia complications: ( )
Discharge with escort: ( )
Instruction given: ( )
Discharge Criteria Met ( )

Discharge Time: _____

Notes:

Surgeon Name: Dr Kim

Anesthesiologist Signature:

DR D KIM 11-27-17
PARK, MINHYE
F, DOB [redacted]

Post-Operative Recovery Room Record

Patient Name: _____ Date Birth _____ Date: _____
Handoff Required ☐ No ☐ Yes Staff Performing G Info Revised _____

Monitor: _____ Patient Identification Verifies ☐ Verbal ☐ Medical Record

Time In: 1240 via Color ☐ Pink ☐ Pale Breathing ☐ Freely ☐ Obstructed

Response: ☐ Awake and Oriented ☐ Unresponsive Time Responsive: _____

Time	BP	HR	Resps	O2 Saturation	Comments	Initials
Admission Time: 11:40	108/64	62	16	97		Z
1st Eval after Admission: 12:00	100/70	62	17	98		Z
Discharged Time: 12:50	106/60	62	17	98		Z

	Medication	Dsg	RT	Time	Initials
☐	Ibuprofen	600 mg #___	By Mouth		
☐	Tylenol	500mg #1		12:00	Z
☐	Water/Tea		PO		
☒	Hard candy				
☐	Orange Juice				
☐	Coffee				
☐	Apple Juice				

Bleeding ☐ Scant ☐ Moderate ☐ Heavy

Pain Scale - Initial — Ask patient to point to face that best described their level of pain

0. No Pain 1. Mild Pain 2. Discomfort 3. Distressing 4. Intense 5. Excruciating

Pain Scale -Discharge — Ask patient to point to face that best described their level of pain

0. No Pain 1. Mild Pain 2. Discomfort 3. Distressing 4. Intense 5. Excruciating

Discharge Scoring System:		OUT
Able to do normal activity for age Minimal Assist Ambulate with assistance	2 1 0	Z
VS +/- 20% Pre-op level/stable VS +/- 20-50% Pre-op level/stable VS +/- 60% pre-op level/stable	2 1 0	Z
Voided Voiding small amounts Unable to void	2 1 0	Z
Tolerating liquids / solids well Needs encouragement to drink Not drinking. IV still infusing	2 1 0	Z
Minimal or no nausea & vomiting Moderate nausea & vomiting Unable to control nausea & vomiting	2 1 0	Z
Minimal or No Bleeding Bleeding Within Normal Limits Excessive Bleeding	2 1 0	Z
Totals: _____		6

Discharge Status: Time of Discharge: 13:00

Ambulatory? ☐ Yes ☐ No _____
Instructions given: ☐ Yes To: ☐ Patient ☐ Caregiver
Patient Understands Post-up Instructions ☐ Yes
Patient Mental Status ☐ WNL ☐ Altered _____
Post-op Appointment made: ☐ Yes
Pain Management Plan:
☐ Pain 4 or less take pain medication as instructed in postoperative instructions
☐ Pain level greater than 4: MD plan:

_____
_____
_____

☐ Patient cleared for discharge home with an escort in stable condition. Patient indicates she is feeling well
Notes _____
_____

Discharged by: _____ M.D.

Physician Name:

PRE-OPERATIVE HISTORY AND PHYSICAL EXAMINATION

Patient Name: _____ **DOB:** _____ **Date:** _____

HEIGHT 5'4 **WEIGHT** 110 **TEMP** 98 **PULSE** 62 **BP** 98/60 **NPO** 11 **# hours**

ALLERGIES/ DRUG SENSITIVITIES NKDA

Previous Serious Illness and Surgeries _____

_____

Pertinent Labs: ☐ **Urine Pregnancy** ☐ Positive ☐ Negative ☐**RH** ☐ Positive ☐ Negative
☐**NONE** ☐ **Other Labs** _____

Current/Chronic Medical Issues: _____

_____

Barriers to learning ☐ None ☐ Site impairment ☐ Hearing ☐ Speech ☐ Language _____
☐ Level of Understanding ☐ Psychosocial Status _____ ☐ Cultural Considerations _____

Plan for Effective Teaching/Education
☐ Translation Services _____ ☐ Large Print Materials ☐ Translated Written Materials
☐ Other _____

MEDICATION MANAGEMENT:
Current Medications ☐Unchanged from intake
☐ Other, explain _____
Anticoagulants? ☐ Yes ☐ No last dose? _____

PHYSICAL ASSESSMENT
Heart: ☐ Normal ☐ Other _____
Lungs ☐ Normal ☐ Other _____
Other (applicable to area to be treated) ☐ Normal ☐Other _____
General Appearance: ☐ Normal ☐ Other _____
Review of Systems ☐ WNL ☐ Other, explain _____
Bleeding Tendencies ☐ None ☐ Other _____
Other pertinent finding: _____
IMPRESSION (Pre-op diagnosis and proposed procedure) _____

_____

_____

_____

TIME OUT PROCEDURE
VERIFIED: Correct Patient? ☐ **Name** ☐ **Date of birth**

Correct surgery with patient? ☐Yes ☐ No Informed Consent Obtained? ☐ Yes 2 Person Agreement ☐ Yes

☐ Site marking n/a ☐ Surgery Site Marked

Cleared for Procedure ☐ *Yes* ☐ *No, Reason* _____

Physician Signature: _____ Date _____

Procedure Start Time _____ Procedure End Time _____

NewPath Diagnostics

42-11 Parsons Boulevard, 1ST FL., Flushing, NY 11355
Phone 718-321-1108; Fax 718-321-0158

WOMEN'S HEALTH PATHOLOGY REPORT

PATIENT	PHYSICIAN	SPECIMEN
PARK,MINHYE Age: 28 DOB: [redacted] Sex: Female	DAVID KIM, M.D. 136-20 38th Avenue 5I Flushing, NY 11354 Tel #: 718-939-9200 Fax#: 718-939-7474	Accession #: S17-10254 Date Collected: 11/27/2017 Date Received: 11/27/2017 Date Reported: 12/04/2017 # of Jars received: 1 Service type: GLOBAL

FINAL DIAGNOSIS:

PRODUCT OF CONCEPTION, CURETTAGE

- **Decidua with reactive changes. No villi seen.**

Note: Report faxed to Dr. Kim's office (12/03/2017).

GROSS DESCRIPTION:

Product of conception, curettage received in formalin is multiple fragment(s) of tan, soft tissue measuring 20x20x20 mm with possible villi but no fetal parts. The specimen is entirely submitted in 2 cassettes.

PATHOLOGIST:

Jianyou Tan, M.D., Ph.D./ Electronically Signed

CPT: 88305
ICD10: Z33.2